insertion of foreign body only. Admitting clinicians frequently have their requests questioned by diagnostic radiographers regarding their suitability. This study assessed if clinicians undertake "gaming behaviour" by fabricating clinical information to get the test they desire, rather than what is indicated.
Method: 50 random AXRs performed in October 2015 in our institution were selected from a PACS search. The notes were then retrieved, and written clinical and ICE request information was assessed for congruency. It was also noted if the AXR was normal or showed pathology and the clinical background of the requestor.
Result: 42% of AXRs had ICE request information that was either an elaboration or complete fabrication from the clinical history and examination. 80% of these produced a normal AXR. The majority were requested by an A&E clinician.
Conclusion: There is a significant overuse of AXR in the Acute Abdomen by clinicians fabricating information to "get through the system". They can be reassured that this imaging is indeed unnecessary as indicated by RCR guidance.

http://dx.doi.org/10.1016/j.ijsu.2016.08.184

0732: DOES CT SCAN CHANGE THE MANAGEMENT OF PATIENTS AGED OVER 50 WHO PRESENT WITH SUSPECTED APPENDICITIS?

A. Al-Amin[*], M. El-Haddad, A. Krishnan, A. Ahmad, I. Jaradat. *Pinderfields General Hospital, Wakefield, UK.*

Aim: to determine whether routine requests for CT abdomen/pelvis alter management of patients over the age of 50 presenting with a clinical picture of acute appendicitis during their work-up.
Method: retrospective study. Records of patients meeting inclusion criteria were retrieved from acute surgical handover electronic records. CT scan findings were compared to clinical diagnosis. Proportion of patients who did not undergo a standard appendicectomy was calculated.
Result: 25 patients included. 8 female, 17 male, ages 50-85, median age 61 years. 4 patients did not have a CT scan, 21 were scanned. Of those that were scanned, 5 (23.8%) did not have an operation because of CT scan findings differing from clinical suspicion. Of those, 3 had alternative diagnoses, 1 had an appendix mass which was percutaneously drained, whist another had a suspected caecal tumour with secondary appendicitis, but not fit for surgery. Of the 4 not scanned, all underwent a laparoscopy - 3 appendicitis and 1 showed caecal thickening with a normal appendix (not removed).
Conclusion: CT scan changed the management of 20% of the patients as they did not require an appendicectomy. Of the few that were not scanned, one of them had an alternative pathology requiring further investigation.

http://dx.doi.org/10.1016/j.ijsu.2016.08.185

0806: ASSESSING DISTRACTION OF UNSTABLE CERVICAL SPINE FRACTURES WITH INCORRECTLY FITTED RIGID COLLARS - A CADAVERIC STUDY

G. Janakan[1,*], G. Jayasinghe[2], A. Eaglen[3], D. Bew[1]. [1] *King's College Hospital, London, UK;* [2] *King's College London, London, UK;* [3] *St Thomas' Hospital, London, UK.*

Aim: Rigid collars need to be properly sized prior to placement on patients with cervical spine fractures. There has been no study to date looking at the degree of fracture distraction when a wrongly sized collar is used.
Method: The integrity of the cadavers' cervical spine were disrupted using a variety of techniques and access points (trans oral, trans foramen magnum and posterior neck approach). The fracture patterns assessed all involved two or three columns (C1 burst fracture, occipito-atlas dislocation, rupture of the atlas transverse ligament and odontoid peg fracture). The standard three view (anterior-posterior, lateral and odontoid peg) plain radiographs were performed on these cadavers with cervical hard collars fitted into different positions (no neck, short, regular and tall).
Result: The plain radiograph images had been degraded by artefact created by air entering the soft tissues (spinal canal and posterior neck) during dissection. There were no significant changes in the fractured segments when the rigid collar was placed in any position.
Conclusion: Incorrectly fitted hard collars did not worsen the fracture pattern of unstable cervical fractures. There are limitations to this study based on the air artefact created when making a fracture.

http://dx.doi.org/10.1016/j.ijsu.2016.08.186

0810: MANAGEMENT OF PENETRATING CHEST INJURIES AT A MAJOR TRAUMA CENTRE WITH AN OFF-SITE CARDIOTHORACIC HOSPITAL

N. McCartan[1,*], G. Kleftouris[2], S. Scott[2]. [1] *School of Medicine, University of Liverpool, Liverpool, UK;* [2] *Aintree University Hospital, Liverpool, UK.*

Aim: To evaluate the management of penetrating chest injuries at a major trauma centre with an off-site cardiothoracic hospital 20 minutes away. It was hoped that identification of best practice would lead to the development of a protocol to standardise management and improve outcomes.
Method: Data was collected retrospectively from all penetrating chest trauma admissions to Aintree University Hospital, Liverpool between August 2014 and July 2015. Cases were included if they fulfilled the Trauma Audit and Research Network (TARN) criteria for a major trauma. Electronic records from each admission, including prehospital and operative notes, were analysed to complete data points.
Result: In total, 21 out of 92 patients admitted with penetrating thoracic injuries fulfilled TARN criteria for inclusion. Of these, six required a thoracotomy. Four underwent thoracotomy on-site, one of whom was later transferred off-site for further thoracotomy. Each patient who underwent thoracotomy on-site survived to discharge.
Conclusion: The heterogeneity within penetrating chest trauma cases is a major obstacle to standardising their management. On-site cardiothoracic expertise is required at the time of admission for patients that may need thoracotomy, as transfer off site is often unfeasible. Development of a centre-specific protocol can guide and streamline management if implemented effectively.

http://dx.doi.org/10.1016/j.ijsu.2016.08.187

0814: EMERGENCY ABDOMINAL ARTERIAL HEMORRHAGE: MULTIPHASE CT APPEARANCES AND THE ROLE OF THE INTERVENTIONAL RADIOLOGIST

O. Al-Fagih[1,*], H. Chaudhary[2]. [1] *Bedford Hospital NHS Trust, Bedford, UK;* [2] *St Helens and Knowsley Hospitals NHS Trust, Liverpool, UK.*

Aim: One of the most preventable causes of death in abdominal and pelvic trauma is arterial hemorrhage that goes untreated or unrecognized. Over the last decade, radiology has undergone many advances, particularly in noninvasive imaging and interventional angiography, such that critical arterial hemorrhage is both recognized and treated faster, often with life-preserving results
Method: We collated a series of cases that demonstrate the appearances of arterial hemorrhage on multiphase CT. We highlight the important features and pitfalls that the surgeon should recognize on imaging. We discuss how involving the Interventional Radiologist at an eary stage can improve patient mortality in these critical cases without the need for emergency surgery. Pre-surgical embolization to achieve hemostasis in some cases can postpone surgical intervention and also dramatically reduce intra-operative bleeding.
Conclusion: The role of the IR is becoming increasingly important, not only in emergency hemostasis but also in stabilization for later surgery. Surgeons need to be aware of this important resource and be acquainted with the CT imaging appearances.

http://dx.doi.org/10.1016/j.ijsu.2016.08.188

0820: CLINICAL OUTCOMES OF EMERGENCY HARTMANN'S PROCEDURE

D. Vijayan[1,*], M.C. Raphael[1], L. Gault[2], J. Dmitrewski[1]. [1] *University Hospitals Birmingham, Birmingham, UK;* [2] *University of Birmingham, Birmingham, UK.*